Miyasaka Eye Care Today's date:_____

Medical History Questionnaire

Last name: _____ First name: _____MI: _____Date of birth: _____

Patient Ocular History: Please indicate if you have or have ever been diagnosed with the following conditions or symptoms.

☐ Blurred vision	☐ Dry eyes	☐ Flashes	☐ Cataracts	☐ Discharge from eyes
☐ Eyestrain	☐ Teary eyes	☐ Floaters	☐ Amblyopia (lazy eye)	☐ Loss of vision
☐ Double vision	☐ Red eyes	☐ Eye pain/irritation	☐ Strabismus (eye turn)	☐ Macular degeneration
☐ Blindness	☐ Itchy eyes	☐ Retinal disease	☐ Glaucoma	☐ Eye injury

Eye surgery (type and date): _____

Other: _____

Date of last eye exam:_____ Doctor's name:_____ Were your eyes dilated? ☐ No | ☐ Yes

Do you currently wear contact lenses? ☐ No | ☐ Yes: Type? ☐ Hard/Gas Permeable | ☐ Soft | ☐ Multifocal
Cleaning Solution:_____
Right eye: Brand:_____ Power:_____ Base Curve (BC): _____
Left eye: Brand:_____ Power:_____ Base Curve (BC): _____

Are you interested in laser refractive surgery? ☐ No ☐ Yes

Patient Medical History: Please indicate if you have ever been diagnosed with the following medical conditions.

☐ High blood pressure	☐ High cholesterol	☐ Rheumatoid disease	☐ Diabetes: Date diagnosed _____ last HA1c & when? _____
☐ Headaches	☐ Heart disease	☐ Thyroid disease	☐ Cancer: type _____

Surgeries (type and date): _____

Other: _____

Medications: Please list the name, dosage, and frequency for all medications currently taken, including eye drops, supplements and OTC medications.

_____

Allergies: Do you have any allergies? If yes, please list all food, drug, and any other allergies you may have.

☐ No ☐ Yes:_____

Review of Systems: Do you currently or have you recently had any of the following conditions? If yes, please explain.

Constitution (e.g. chronic fever, recent weight loss or gain, fatigue)	☐ No	☐ Yes: _____
Cardiovascular (e.g. chest pain, irregular heart beat, high blood pressure)	☐ No	☐ Yes: _____
Ears, Nose, Mouth, Throat (e.g. hearing loss, sinus, vertigo, dry mouth)	☐ No	☐ Yes: _____
Respiratory (e.g. shortness of breath, coughing, asthma, congestion)	☐ No	☐ Yes: _____
Gastrointestinal (e.g. heartburn, abdominal pain, diarrhea, vomiting, ulcers)	☐ No	☐ Yes: _____
Genitourinary (e.g. pain or discomfort, blood in urine, prostate problems)	☐ No	☐ Yes: _____
Musculoskeletal (e.g. muscle ache, joint pain, swollen joints, arthritis)	☐ No	☐ Yes: _____
Integumentary (e.g. rash, excessive dryness, hives, acne)	☐ No	☐ Yes: _____
Neurological (e.g. numbness, weakness, headaches, paralysis, strokes)	☐ No	☐ Yes: _____
Psychiatric (e.g. depression, anxiety, trouble sleeping)	☐ No	☐ Yes: _____
Endocrine (e.g. hypothyroid, hyperthyroid diabetes)	☐ No	☐ Yes: _____
Hematologic/Lymphatic (e.g. cholesterol, anemia, enlarged lymph glands)	☐ No	☐ Yes: _____
Allergic/Immunologic (e.g. hay fever, Lupus, Sjogren's, HIV/AIDS)	☐ No	☐ Yes: _____

Social History:

Do you smoke? ☐ No: ☐ Never smoked -or- ☐ Former smoker
☐ Yes: How often? ☐ Daily -or- ☐ Some days. How much? ☐ ½ pack, ☐ 1 pack, ☐ other:_____

Do you use recreational drugs? ☐ No ☐ Yes, Drug used:_____

Miyasaka Eye Care Today's date:_____

Medical History Questionnaire

Do you smoke? ☐ No: ☐ Never smoked -or- ☐ Former smoker
☐ Yes: How often? ☐ Daily -or- ☐ Some days. How much? ☐ ½ pack, ☐ 1 pack,
☐ other:_____

Hobbies/Avocation:_____

Level of education (high school, vocational school, college, BA, BS, graduate degree, etc): _____

Do you have special visual needs? _____

Family History: Please indicate if there is a family history of the following medical conditions.
Indicate the relationship to patient: M = mother F = father B = brother S = sister GM = grandmother
GF = grandfather U = uncle A = aunt

Glaucoma_____
Retinal disease _____
Cataract _____
Macular degeneration _____
Blindness _____
Strabismus _____
Other _____

Diabetes_____
Cancer _____
Heart Disease _____
Hypertension _____
High Cholesterol _____
Other _____